STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	10/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00096308. This visit was done in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00095419 completed on September 6, 2011. Complaint IN00096308 Substantiated, Federal/State deficiencies related to the allegations are cited at F157, F241, F282, F514 Survey dates: October 5 and 6, 2011 Facility number: 012448 Provider number: 155785 AIM number: N/A Survey team: Anne Marie Crays RN Census bed type: SNF: 26 Residential: 52 Total: 78 Census payor type: Medicare: 19 Other: 69 Total: 78 Sample: 5	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 10/12/11 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to ensure the physician was notified of residents not receiving their medication, for 2 of 3 residents reviewed for physician notification, in a sample of 5. Resident B, Resident A Findings include:	F0157	F157 Resident B's MAR and physcian orders were compared to ensure accuracy andavailability. Staff that administer medication to her have been inserviced on those orders.Completion Date 10-31-11Residents A's MAR and TAR have been compared to ensure accuracy and staff that	10/31/2011

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	1. The clinical record of Resident B was reviewed on 10/5/11 at 2:25 P.M. A Physician's order, dated 8/25/11, indicated, "Ondonsetron [otherwise known as Zofran, for nausea] 4 mg tab PO [by mouth] QAM [every morning] before rising et [and] PRN [as needed] Q [every] 6-8 [hours] nausea/vomiting x 7 days." A MAR, dated August 2011, indicated a blank space on 8/26, and circled initials on 8/27, 8/28, and 8/29. Documentation of an explanation for the circled initials was lacking. A hospice note, dated 8/30/11, indicated, "...Drug: Ondonsetron (Zofran)...effective? Other: had not been given...Mood: upset about lack of care/meds given...Summary of visit...Pt [patient] very nauseated. Zofran not started but in Pt's med drawer. This HRN [hospice nurse] administered Zofran...." A hospice note, dated 8/31/11, indicated, "...Pt states better since Zofran started...Spoke to ADON [Assistant Director of Nursing] [name] re: problem [with] pt getting meds when due...." A Medication Administration Record, dated September 2011, indicated, "Requip 2 mg Give 1 tablet by mouth every bedtime for restless leg syndrome."		administer medication to him have been inserviced on those orders.Completion Date 10-31-11No other residents were affected by the deficient practice and through inservicing and alteration in documentation will ensure that medications that are not administered as they are ordered will have reason why and documentation of physcian notification.Completion Date 10-31-11Licensed nursing staff inserviced on proper medication administration procedures, documentation of physician notification related to meds when held, refused or omitted.Completion Date 10-31-11DHS/Designee will observe 1 nurse per day during med administration rotating shifts and hallways, and fill out observation report upon completion with identified concerns related to dosage, technique, timeframes, documention, etc. Audits will be for 15 days, then 1 per week for 30 days, then 1 mothly. Pharmacist will also randomly observe 1 nurse med pass per month.Results of audits will be forwarded to QA committee monthly x 6 months and quarterly thereafter.	

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	Circled initials were on 9/8, 9/10, 9/13, and 9/14. The reverse of the MAR indicated: "9/8/11 Unavailable. Unable to give Requip. 9/13/11 Not able to give Requip. Unavailable. Pharm faxed. 9/14/11 Unable to give Requip. Fax Pharm [sic]." A hospice note, dated 9/19/11, indicated, "...Spoke to ADON [name] re: care conference D/T [due to] meds missing, not given, ect. [sic]. Will schedule ASAP [as soon as possible]...." Documentation of physician notification of the resident not receiving the medications was lacking. On 10/5/11 at 2:15 P.M., during interview with the Administrator, she indicated the facility was aware of the issue of medication and documentation issues, and that corporate staff had been in the facility for 2 weeks attempting to inservice and retrain staff. 2. On 10/5/11 at 9:55 A.M., during interview with Resident A, he indicated he had resided at the facility approximately 10 months, and during that time the staff had "mixed up" his medication orders several times. Resident A indicated there had been several times when he didn't get his medications and			

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	creams. The clinical record of Resident A was reviewed on 10/5/11 at 10:30 A.M. A June 2011 Medication Administration Record [MAR] included the following: HCTZ [blood pressure medication] 12.5 mg capsule, Give 1 capsule by mouth every morning. The entry for 6/8 was blank. Entries on 6/10, 6/13, 6/14, 6/16, 6/17, and 6/18 were circled initials. Potassium Citrate Give 1 capsule three times daily with meals. Entries were blank on 6/3 and 6/4 lunch, 6/4, 6/5, 6/6, 6/11-6/16 supper. Initials were circled on 6/17 and 6/18 supper, 6/18, breakfast and lunch, and on 6/19 after rising. Doxycycline 100 mg [antibiotic] twice daily, Stop 7/16. An entry was blank on 6/5 supper. Keflex 500 mg [antibiotic] QID [four times daily]. Entries were blank on 6/4 lunch and supper, 6/5 supper, 6/6 supper. Altabex to [left] great toe bid [twice daily] x 3 weeks. Entries were blank on 6/2, 6/3, 6/4 at "6A-6P," and on 6/3, 6/4, 6/5, and 6/6 at "6P-6A." Nystop apply topically to buttocks twice daily. Entries were blank on 6/3, 6/5 and 6/7 at "6P-6A." Silvadene apply to buttocks after nystop powder applied twice daily. Entries were blank on 6/3, 6/5, and 6/7 at "6P-6A." Entries with circled initials were on 6/2 at "6A-6P" and "6P-6A."			

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	Explanation of the blanks or circled initials was lacking. A MAR, dated August 2011, included: Clean bilateral posterior groin [with] normal saline. Apply silver powder. Cover [with] ABD pad, wrap with kerlix. 2-10. Entries were blank from 8/25 through 8/28. Entries with circled initials were on 8/24, 8/29, and 8/30. Explanation of the blanks or circled initials was lacking. A MAR, dated September 2011, included: "Clean bilateral posterior groin [with] NS [normal saline], Apply silva powder to wound bed. Cover [with] ABD [and] wrap [with] kerlix daily. Entries were blank on 9/1, 9/10, 9/11, 9/23, 9/24,9/25, and 9/28. Circled initials were on 9/26. Explanation of the blanks or circled initials was lacking. On 10/6/11 at 11:30 A.M., during interview with the Corporate Nurses, Director of Nursing, and Administrator, they indicated there was a conflict at times if the resident or family did not want to pay for medications that insurance would not cover. They indicated the physician should be notified if the resident does not receive an ordered medication.			

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	3. On 10/5/11 at 4:00 P.M., the Administrator provided the current facility policy on "Medication Administration - General Guidelines," dated 2/10. The policy included: "... If one dose of a vital medication are withheld or refused, the physician is notified." This federal tag relates to Complaint IN00096308. 3.1-5(a)(1)			

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F0241 SS=E	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on interview and record review, the facility failed to ensure call lights were answered in a timely manner, for 2 of 3 residents interviewed in a sample of 5, and for 7 residents listed in Resident Council Minutes. Resident A, Resident D Findings include: During confidential interview with Resident A, alert and oriented as indicated on a roster provided by the Administrator on 10/5/11 at 11:40 A.M., the resident indicated "it takes a long time" for call lights to be answered. The resident indicated nurses at times will turn off the call lights, but not respond to the requests. The resident indicated the call light has been on for up to 45 minutes before staff has responded. During confidential interview with Resident D, an alert and oriented resident as indicated on a roster provided by the Administrator on 10/5/11 at 11:40 A.M., the resident indicated he/she was to receive assistance of staff to transfer, "and sometimes just can't wait and go by myself." The resident indicated he/she was unsure how long it took for call lights	F0241	F241 Res A suffered no ill effects from findings on the 2567L. Resident was assessed to determine identified need was met and assistance was offered. Completion Date 10-31-11Resident D sufferd no ill effects from findings on 2567L. Resident was assessed to determine identified needs were met and assistance was offered.Completion Date 10-31-11All residents who utilize their call lights to communicate their needs for assistance have the potetial to be affected by the alleged deficient practice and through inservicing and quicker response time will meet resident needs.Completion Date 10-31-11Resident Council will establish acceptable response time. Systemic changes include inservicing of all departments to answer call lights with instructions to find a caregiver within established response time. In-Service includes leaving light on for other departments if it requires a nursing caregiver to meet the need.Completion Date 10-31-11Call light response will be monitored by nursing management and department heads to ensure staff responds within the established parameters. Compliance rounds	10/31/2011

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	to be responded to, but "guessed it was 15 minutes or longer." The resident indicated he/she would be better off "next week, when I don't have to wait for help." On 10/5/11 at 2:15 P.M., the Administrator provided Resident Council Minutes, dated 9/27/11. The minutes indicated 7 residents were in attendance. The minutes included: "...NRSNG [nursing] - The call lights are being answered slow...." On 10/6/11 at 12:30 P.M., during interview with the Administrator, she indicated she was unsure if the facility had a policy and procedure related to answering call lights, but that the corporation standard was to respond to call lights within 3 minutes. This federal tag relates to Complaint IN00096308. 3.1-3(t)		will be performed 5 times per week for 30 days then weekly for 30 days, rotating between all shifts. 3 random residents identified as using their call light will be interviewed weekly to ensure compliance with establised parameters. Group interview sessions will be conducted monthly during Resident Council to identify those residens with concerns.Results of all audits and resident council meeting minutes will be reviewed in QA monthly for 6 months and quarterly thereafter.	

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure medications were administered as prescribed by the physician, for 3 of 3 residents reviewed for following physician orders, in a sample of 5. Resident B, C, and A Findings include: 1. On 10/5/11 at 11:40 A.M., during a medication pass, LPN # 1 was observed to administer Resident B a medication for nausea. LPN # 1 indicated the resident did not have additional medications to be administered at that time. The clinical record of Resident B was	F0282	F282Resident B's MAR and physician orders were compared to ensure accuracy and availability. Staff that administer medication to her have been inserviced on those orders.Completion Date 10-31-11Resident A's MAR and TAR have been compared to ensure accuracy and staff that administer medication to him have been inserviced on those orders.Completion Date 10-31-11Resident C no longer resides at the facility.No other residents were affected by the deficient practice and through inservicing and alteration in documentation will ensure that medications that are not administerd as they are ordered will have reason why ad documentation of physician	10/31/2011

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	reviewed on 10/5/11 at 1:45 P.M. A Physician's order, dated 9/26/11, indicated, "Increase KCL [Potassium supplement] 10 mEq to TID [three times daily] instead of daily." LPN # 1 was interviewed at that time regarding the resident not receiving KCL. LPN # 1 then reviewed the Medication Administration Record [MAR], dated October 2011, and found the entry which indicated: "Potassium Cl 10 mEq Give 1 capsule by mouth TID. Rising, Lunch, Supper." The medication was not initialed as given on 10/2/11 rising, or on 10/2, 10/3, 10/4, or 10/5 lunch. LPN # 1 indicated at that time that it was a new order, and she "guessed she could give it at that time," since it wasn't too late after lunch. A Medication Administration Record, dated September 2011, indicated the KCL 10 mEq was not initialed as given on 9/29 lunch, or 9/30 lunch or "HS" [bedtime]. The clinical record was reviewed again on 10/5/11 at 2:25 P.M. A Physician's order, dated 8/25/11, indicated, "Ondonsetron [otherwise known as Zofran, for nausea] 4 mg tab PO [by mouth] QAM [every morning] before rising et [and] PRN [as needed] Q [every] 6-8 [hours] nausea/vomiting x 7 days." A MAR, dated August 2011, indicated a blank space on 8/26, and circled initials on 8/27, 8/28,		notification.Completion Date 10-31-11Licensed nursing staff inserviced on proper medication administration procedures, documentation of physician notification related to meds held, refused or omitted.Completion Date 10-31-11DHS/Desginee will observe 1 nurse per day during med administration rotating shifts and hallways, and fill out observation with identified concerns related to dosage, technque, timeframes, documentation, etc. Audits will be for 15 days, then 1 per week fr 30 days, then 1 monthly. Pharmacist will also randomly observe 1 nurse med pass per month.Results of audits will be fowarded to QA committed monthly x 6 months and quarterly thereafter.	

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	and 8/29. Documentation of an explanation for the circled initials was lacking. A hospice note, dated 8/30/11, indicated, "...Drug: Ondonsetron (Zofran)...effective? Other: had not been given...Mood: upset about lack of care/meds given...Summary of visit...Pt [patient] very nauseated. Zofran not started but in Pt's med drawer. This HRN [hospice nurse] administered Zofran...." A hospice note, dated 8/31/11, indicated, "...Pt states better since Zofran started...Spoke to ADON [Assistant Director of Nursing] [name] re: problem [with] pt getting meds when due...." A Medication Administration Record, dated September 2011, indicated, "Requip 2 mg Give 1 tablet by mouth every bedtime for restless leg syndrome." Circled initials were on 9/8, 9/10, 9/13, and 9/14. The reverse of the MAR indicated: "9/8/11 Unavailable. Unable to give Requip. 9/13/11 Not able to give Requip. Unavailable. Pharm faxed. 9/14/11 Unable to give Requip. Fax Pharm [sic]." A hospice note, dated 9/19/11, indicated, "...Spoke to ADON [name] re: care conference D/T [due to] meds missing,			

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	not given, ect. [sic]. Will schedule ASAP [as soon as possible]...." On 10/5/11 at 3:50 P.M., during interview with the Assistant Director of Nursing, she indicated she met with Resident B's hospice nurse regarding the omission of Zofran. She indicated she did not know why the nursing staff did not administer the drug, and did not know why the initials were circled on the MAR. On 10/6/11 at 1:00 P.M., during interview with the Corporate Nurse, she indicated she was unsure why the Requip was unavailable, but it possibly could have been that hospice provided the medication, and the facility had run out prior to receiving the medication. 2. On 10/5/11 at 11:40 A.M., LPN # 1 was observed to give Resident C the following medications: Lipitor, Multivitamin, Plavix, Potassium Chloride, and Flomax. LPN # 1 also administered the resident Promod [a vitamin supplement]. The clinical record of Resident C was reviewed on 10/5/11 at 1:40 P.M. The resident was admitted to the facility on 9/28/11. Physician orders, dated 9/28/11, included the following medications: Advair inhaler twice daily, Docusate			

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	Sodium twice daily, Lovenox daily, Lasix twice daily, Imdur twice daily, Synthroid daily, Lipitor daily, Metoprolol daily, Multivitamin daily, Prilosec twice daily, Plavix daily, Potassium Chloride daily, Altace daily, Flomax daily and Tricor daily. A Physician's order, dated 10/4/11, indicated, "Promod 30 cc TID [with] med passes." On 10/5/11 at 1:40 P.M., the resident's Medication Administration Record [MAR] was reviewed. The MAR indicated the medications Lipitor, Multivitamin, Plavix, Potassium Chloride, and Flomax were to be administered "After rising." Promod was to be administered "Upon rise, Lunch, Supper." LPN # 1 indicated at that time, that the resident had been refusing some of the medications in the morning, so the staff had been "splitting them up." Documentation was lacking that the resident had refused medications, or that medications had been administered at different times. The resident's clinical record was again reviewed on 10/5/11 at 2:40 P.M. A Medication Record, dated September 2011, indicated initials and times were lacking for "All After Rising Meds," "All Lunch Meds," "All Supper Meds," and "All Bedtime Meds," except for 9/29 and			

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	155785	A. BUILDING 00 B. WING	10/06/2011

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	9/30 "After Rising." On 10/5/11 at 2:15 P.M., during interview with the Administrator, she indicated the facility was aware of the issue of medication and documentation issues, and that corporate staff had been in the facility for 2 weeks attempting to inservice and retrain staff. 3. On 10/5/11 at 9:55 A.M., during interview with Resident A, he indicated he had resided at the facility approximately 10 months, and during that time the staff had "mixed up" his medication orders several times. Resident A indicated there had been several times when he didn't get his medications and creams. The clinical record of Resident A was reviewed on 10/5/11 at 10:30 A.M. A June 2011 Medication Administration Record [MAR] included the following: HCTZ [blood pressure medication] 12.5 mg capsule, Give 1 capsule by mouth every morning. The entry for 6/8 was blank. Entries on 6/10, 6/13, 6/14, 6/16, 6/17, and 6/18 were circled initials. Potassium Citrate Give 1 capsule three times daily with meals. Entries were blank on 6/3 and 6/4 lunch, 6/4, 6/5, 6/6, 6/11-6/16 supper. Initials were circled on			

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	6/17 and 6/18 supper, 6/18, breakfast and lunch, and on 6/19 after rising. Doxycycline 100 mg [antibiotic] twice daily, Stop 7/16. An entry was blank on 6/5 supper. Keflex 500 mg [antibiotic] QID [four times daily]. Entries were blank on 6/4 lunch and supper, 6/5 supper, 6/6 supper. Altabex to [left] great toe bid [twice daily] x 3 weeks. Entries were blank on 6/2, 6/3, 6/4 at "6A-6P," and on 6/3, 6/4, 6/5, and 6/6 at "6P-6A." Nystop apply topically to buttocks twice daily. Entries were blank on 6/3, 6/5 and 6/7 at "6P-6A." Silvadene apply to buttocks after nystop powder applied twice daily. Entries were blank on 6/3, 6/5, and 6/7 at "6P-6A." Entries with circled initials were on 6/2 at "6A-6P" and "6P-6A." Explanation of the blanks or circled initials was lacking. A MAR, dated August 2011, included: Clean bilateral posterior groin [with] normal saline. Apply silver powder. Cover [with] ABD pad, wrap with kerlix. 2-10. Entries were blank from 8/25 through 8/28. Entries with circled initials were on 8/24, 8/29, and 8/30. Explanation of the blanks or circled initials was lacking. A MAR, dated September 2011, included: "Clean bilateral posterior groin [with] NS [normal saline], Apply silva powder to			

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	wound bed. Cover [with] ABD [and] wrap [with] kerlix daily. Entries were blank on 9/1, 9/10, 9/11, 9/23, 9/24,9/25, and 9/28. Circled initials were on 9/26. Explanation of the blanks or circled initials was lacking. On 10/6/11 at 11:30 A.M., during interview with the Corporate Nurses, Director of Nursing, and Administrator, they indicated there was a conflict at times if the resident or family did not want to pay for medications that insurance would not cover. They indicated there should be documentation on why a medication was missed. 4. On 10/5/11 at 4:00 P.M., the Administrator provided the current facility policy on "Medication Administration Times Procedural Guidelines," undated. The policy included: "...Unless a specific time is designated by the attending physician medications shall be administered at the following times: a. QD [every day] - after there resident awakes in the morning (morning is designated as times between 4 AM and 10 AM). b. BID [twice daily] - in the morning and at bedtime (bedtime is generally from 8 PM to Midnight). c. TID [three times daily] - in the morning, around lunch time and at bedtime (lunch time is usually between 11 AM and 1:30			

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	PM)...The nurse administering the medications shall record the time the medication was administered along with his/her initials. a. The nurse shall note the time of the previous dose prior to administering the same medication to ensure it is not provided too close together...Medications that have been ordered at a specific time shall be administered a t the time designated by the attending physician." On 10/5/11 at 4:00 P.M., the Administrator provided the current facility policy on "Medication Administration - General Guidelines," dated 2/10. The policy included: "...Medications are administered in accordance with written orders of the attending physician...At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented...If a dose of regularly scheduled medication is withheld, refused, or given at other that the scheduled time...the space provided on the front of the MAR for that dosage administrations is (initialed and circled) [sic]. An explanatory note is entered on the reverse side of the record provided for PRN [as needed] documentation. If one dose of a vital medication are withheld or refused, the physician is notified."			

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	This federal tag relates to Complaint IN00096308. 3.1-35(g)(2)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			

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	Based on observation, interview and record review, the facility failed to ensure documentation was complete and accurate on the medication administration record, for 3 of 3 residents reviewed for documentation, in a sample of 5. Residents B, C, and A Findings include: 1. On 10/5/11 at 11:40 A.M., during a medication pass, LPN # 1 was observed to administer Resident B a medication for nausea. LPN # 1 indicated the resident did not have additional medications to be administered at that time. The clinical record of Resident B was reviewed on 10/5/11 at 1:45 P.M. A Physician's order, dated 9/26/11, indicated, "Increase KCL [Potassium supplement] 10 mEq to TID [three times daily] instead of daily." LPN # 1 was interviewed at that time regarding the resident not receiving KCL. LPN # 1 then reviewed the Medication Administration Record [MAR], dated October 2011, and found the entry which indicated: "Potassium Cl 10 mEq Give 1 capsule by mouth TID. Rising, Lunch, Supper." The medication was not initialed as given on 10/2/11 rising, or on 10/2, 10/3, 10/4, or 10/5 lunch. LPN # 1 indicated at that time that it was a new order, and she "guessed	F0514	F514Resident B's MAR and physician orders were compared to ensure accuracy and availability. Staff that administer medication to her have been inserviced on those orders.Completion Date 10-31-11Resident A's MAR and TAR have been compared to ensure accuracy and staff that administer medication and treatments to him have been inserviced on those orders.Completion Date 10-31-11Resident C no longer resides in the facility.No other residents were affected by the deficient practice and through inservicing and alteration in documentation will ensure that medications/treatments that are not administered as they are ordered will have reason why and documentation of physician notification.Completion Date 10-31-11Licensed nursing staff inserviced on proper medication administration procedures, documentation of physician notification related to meds/tx's when held, refused or omitted.Completion Date 10-31-11DHS/Designee will observe 1 nurse per day during med administration rotatig shifts and hallways, and fill out observation report upon completion with identified concerns related to dosage, technique, timeframe, documentation,etc. Audits will be for 15 days, then 1 per week for	10/31/2011

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	she could give it at that time," since it wasn't too late after lunch. A Medication Administration Record, dated September 2011, indicated the KCL 10 mEq was not initialed as given on 9/29 lunch, or 9/30 lunch or "HS" [bedtime]. The clinical record was reviewed again on 10/5/11 at 2:25 P.M. A Physician's order, dated 8/25/11, indicated, "Ondonsetron [otherwise known as Zofran, for nausea] 4 mg tab PO [by mouth] QAM [every morning] before rising et [and] PRN [as needed] Q [every] 6-8 [hours] nausea/vomiting x 7 days." A MAR, dated August 2011, indicated a blank space on 8/26, and circled initials on 8/27, 8/28, and 8/29. Documentation of an explanation for the circled initials was lacking. A Medication Administration Record, dated September 2011, indicated, "Requip 2 mg Give 1 tablet by mouth every bedtime for restless leg syndrome." Circled initials were on 9/8, 9/10, 9/13, and 9/14. The reverse of the MAR indicated: "9/8/11 Unavailable. Unable to give Requip. 9/13/11 Not able to give Requip. Unavailable. Pharm faxed. 9/14/11 Unable to give Requip. Fax Pharm [sic]."		30 days, then 1 monthly. Pharmacist wll also randomly observe 1 nurse med pass per month.Results of audits will be forwarded to QA committee monthly x 6 months and quarterly thereafter.	

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	On 10/5/11 at 3:50 P.M., during interview with the Assistant Director of Nursing, she indicated she met with Resident B's hospice nurse regarding the omission of Zofran. She indicated she did not know why the nursing staff did not administer the drug, and did not know why the initials were circled on the MAR. 2. On 10/5/11 at 11:40 A.M., LPN # 1 was observed to give Resident C the following medications: Lipitor, Multivitamin, Plavix, Potassium Chloride, and Flomax. LPN # 1 also administered the resident Promod [a vitamin supplement]. The clinical record of Resident C was reviewed on 10/5/11 at 1:40 P.M. The resident was admitted to the facility on 9/28/11. Physician orders, dated 9/28/11, included the following medications: Advair inhaler twice daily, Docusate Sodium twice daily, Lovenox daily, Lasix twice daily, Imdur twice daily, Synthroid daily, Lipitor daily, Metoprolol daily, Multivitamin daily, Prilosec twice daily, Plavix daily, Potassium Chloride daily, Altace daily, Flomax daily and Tricor daily. A Physician's order, dated 10/4/11, indicated, "Promod 30 cc TID [with] med passes." On 10/5/11 at 1:40 P.M., the resident's			

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	Medication Administration Record [MAR] was reviewed. The MAR indicated the medications Lipitor, Multivitamin, Plavix, Potassium Chloride, and Flomax were to be administered "After rising." Promod was to be administered "Upon rise, Lunch, Supper." LPN # 1 indicated at that time, that the resident had been refusing some of the medications in the morning, so the staff had been "splitting them up." Documentation was lacking that the resident had refused medications, or that medications had been administered at different times. The resident's clinical record was again reviewed on 10/5/11 at 2:40 P.M. A Medication Record, dated September 2011, indicated initials and times were lacking for "All After Rising Meds," "All Lunch Meds," "All Supper Meds," and "All Bedtime Meds," except for 9/29 and 9/30 "After Rising." On 10/5/11 at 2:15 P.M., during interview with the Administrator, she indicated the facility was aware of the issue of medication and documentation issues, and that corporate staff had been in the facility for 2 weeks attempting to inservice and retrain staff. 3. On 10/5/11 at 9:55 A.M., during			

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	interview with Resident A, he indicated he had resided at the facility approximately 10 months, and during that time the staff had "mixed up" his medication orders several times. Resident A indicated there had been several times when he didn't get his medications and creams. The clinical record of Resident A was reviewed on 10/5/11 at 10:30 A.M. A June 2011 Medication Administration Record [MAR] included the following: HCTZ [blood pressure medication] 12.5 mg capsule, Give 1 capsule by mouth every morning. The entry for 6/8 was blank. Entries on 6/10, 6/13, 6/14, 6/16, 6/17, and 6/18 were circled initials. Potassium Citrate Give 1 capsule three times daily with meals. Entries were blank on 6/3 and 6/4 lunch, 6/4, 6/5, 6/6, 6/11-6/16 supper. Initials were circled on 6/17 and 6/18 supper, 6/18, breakfast and lunch, and on 6/19 after rising. Doxycycline 100 mg [antibiotic] twice daily, Stop 7/16. An entry was blank on 6/5 supper. Keflex 500 mg [antibiotic] QID [four times daily]. Entries were blank on 6/4 lunch and supper, 6/5 supper, 6/6 supper. Altabex to [left] great toe bid [twice daily] x 3 weeks. Entries were blank on 6/2, 6/3, 6/4 at "6A-6P," and on 6/3, 6/4, 6/5, and 6/6 at "6P-6A." Nystop			

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	apply topically to buttocks twice daily. Entries were blank on 6/3, 6/5 and 6/7 at "6P-6A." Silvadene apply to buttocks after nystop powder applied twice daily. Entries were blank on 6/3, 6/5, and 6/7 at "6P-6A." Entries with circled initials were on 6/2 at "6A-6P" and "6P-6A." Explanation of the blanks or circled initials was lacking. A MAR, dated August 2011, included: Clean bilateral posterior groin [with] normal saline. Apply silver powder. Cover [with] ABD pad, wrap with kerlix. 2-10. Entries were blank from 8/25 through 8/28. Entries with circled initials were on 8/24, 8/29, and 8/30. Explanation of the blanks or circled initials was lacking. A MAR, dated September 2011, included: "Clean bilateral posterior groin [with] NS [normal saline], Apply silva powder to wound bed. Cover [with] ABD [and] wrap [with] kerlix daily. Entries were blank on 9/1, 9/10, 9/11, 9/23, 9/24,9/25, and 9/28. Circled initials were on 9/26. Explanation of the blanks or circled initials was lacking. On 10/6/11 at 11:30 A.M., during interview with the Corporate Nurses, Director of Nursing, and Administrator, they indicated there was a conflict at			

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	times if the resident or family did not want to pay for medications that insurance would not cover. They indicated there should be documentation on why a medication was missed. 4. On 10/5/11 at 4:00 P.M., the Administrator provided the current facility policy on "Medication Administration Times Procedural Guidelines," undated. The policy included: "...Unless a specific time is designated by the attending physician medications shall be administered at the following times: a. QD [every day] - after there resident awakes in the morning (morning is designated as times between 4 AM and 10 AM). b. BID [twice daily] - in the morning and at bedtime (bedtime is generally from 8 PM to Midnight). c. TID [three times daily] - in the morning, around lunch time and at bedtime (lunch time is usually between 11 AM and 1:30 PM)...The nurse administering the medications shall record the time the medication was administered along with his/her initials. a. The nurse shall note the time of the previous dose prior to administering the same medication to ensure it is not provided too close together...." On 10/5/11 at 4:00 P.M., the Administrator provided the current facility			

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	policy on "Medication Administration - General Guidelines," dated 2/10. The policy included: "...Medications are administered in accordance with written orders of the attending physician...At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented...If a dose of regularly scheduled medication is withheld, refused, or given at other that the scheduled time...the space provided on the front of the MAR for that dosage administrations is (initialed and circled) [sic]. An explanatory note is entered on the reverse side of the record provided for PRN [as needed] documentation...." This federal tag relates to Complaint IN00096308. 3.1-50(a)(1) 3.1-50(a)(2)			

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